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Stigma and student mental health in higher education

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Stigma is a powerful force in preventing university students with mental health difficulties from gaining access to appropriate support. This paper reports on an exploratory study of university students with mental health difficulties that found most students did not disclose their mental health problems to staff at university. This was primarily due to fear of discrimination during their studies and in professional employment. Many students went to considerable efforts to hide their mental health condition and in doing so struggled to meet university requirements. Of the minority who did disclose, most received helpful assistance with both their studies and management of their mental health condition. The university was the main source of support services including counselling, disability, student union and housing. A range of measures are required to address the impact of stigma and mental health to empower students so that they can disclose in the confidence that they will be treated fairly.

Keywords: disclosure of mental health problems; higher education; power; stigma

Introduction

The severity and high levels of disability associated with mental illness have led to increased global efforts to address mental health problems, in particular those targeted at prevention. In recent years, mental health and wellbeing have been identified as priority areas by the World Health Organisation, the World Bank and government leaders’ worldwide (Knapp, McDaid, Mossialos, & Thornicroft, 2007). This is within the context of a severe shortage of resources, particularly in low- and middle-income countries (World Health Organisation (WHO), 2009). Mental health problems have been predicted to be the largest single burden of illness globally within the next two decades (Mathers & Loncar, 2006). Mental health difficulties affect all ranges of people regardless of age, gender, religion or race, however, first onset has been found to be most prevalent in young people. Three quarters of those who develop mental illness do so between the ages of 16 and 25, an age when most young people are likely to embark on post-secondary education and training programs (Mcgivern, Pellerita, & Mowbray, 2003; McLean & Andrews, 1999). This paper reports on research that examined the mental health and wellbeing of students enrolled at a university in Melbourne, Australia. First, mental health, post-secondary education and the service delivery context are considered. This is followed by a discussion of the stigma associated with mental illness and the discrimination and disadvantage that can occur. The findings of a study of students with a mental health condition that has affected their

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university studies are presented. A focus is on the main difficulties these students encountered and the most helpful assistance provided to them.

**Mental health and higher education**

Many individuals who experience mental health difficulties want to undertake post-secondary education (Mansbach-Kleinfield, Sasson, R., Shvarts, & Grinshpoon, 2007; Shankar, Martin, & McDonald, 2009). This aspiration is supported in Conventions, legislation, standards and polices on disability, education and mental health. Australia ratified the United Nations Convention on the Rights of Persons with Disabilities on 17 July 2008. As a result Australia is now signatory to a legally binding standard that recognises people with disabilities, including mental illness, as equal and active citizens. This Convention, (in particular Article 4 on Education), requires States to recognise the rights of people with a disability to ‘an inclusive education and lifelong learning that will enable them to realise their potential’ (p. 3). Accordingly all people are to be provided with opportunities to reach their full potential, regardless of their disability. A focus of the Convention is on the protection and violation of human rights and how to support people with a disability exercise their rights. This Convention is supported in Commonwealth legislation in the Disability Discrimination Act, 1992, the Disability Standards for Education, 2005, the Australian Vice-Chancellor’s Committee Guidelines for Students with a Disability, 2006 as well as State mental health legislation and policy.

The Equitable Assessment Arrangements policy and Special Consideration policy of the university where the study was undertaken, have been designed within this regulatory framework. The Equitable Assessment Arrangements policy provides for pro-active planning so that adjustments can be made to the learning and assessment environment to ensure equity. Special Consideration is a one-off, reactive variation of an assessment due to unexpected or extraordinary circumstances that have affected performance in assessment activities or prevented them from being undertaken. The granting of equitable assessment arrangements and special consideration is based upon supporting documentation from a qualified practitioner, registered with a recognised body. In the case of special consideration this documentation must demonstrate a severe impact.

This study was undertaken in the State of Victoria with the Mental Health Reform Strategy 2009–2019 (Reform Area 5) identifying ‘improved participation in education and training and in the workforce’ as a key outcome (p. 103).

At the commencement of their studies a student may have a pre-existing mental health condition or they may experience stress that can trigger a first episode of mental illness. The nature of the studies may generate stress that can lead to mental health difficulties. The incidence of mental health problems amongst university students is steadily increasing with estimates of between 10 and 20% (Collins & Mowbray, 2005). Of particular concern are reports that these students have lower completion rates than all other disability groups (Cavallaro, Foley, Saunders, & Bowman, 2005; Moisey, 2004).

The stigma associated with mental illness and the hidden nature of the disability constitute powerful barriers to students seeking and receiving assistance (Martin & Oswin, 2008). Nevertheless, there is increased evidence that students’ with mental health problems who receive appropriate support are successful in post-secondary education (Mcgivern et al., 2003) experience decreased hospitalisation rates (Isenwater,
Lanham, & Thornhill, 2002) and increased levels of self-confidence, self-efficiency and empowerment (Collins, Bybee, & Mowbray, 1998).

Stigma

Stigma is a socially constructed mark of disapproval, shame or disgrace that causes significant disadvantage through the curtailment of opportunities. Reidpath Chan, Gifford and Allotey (2005) describe stigma as: ‘a mark borne by a person judged as unfit for the sharing of social resources, and stigmatisation is a process for controlling community membership or ensuring active social exclusion’ (p. 5). Negative impacts on health and wellbeing are experienced by those who are excluded. The effects of stigma have been seen as contributing to an overwhelming sense of fear and isolation for the individual affected with stigma regarded as the most debilitating aspect of mental illness (Granello & Wheaton, 2001; SANE Australia, 2006). Erving Goffman’s (1974) classic sociological writings on stigma highlight the central feature that the question of acceptance has in the life of the stigmatised individual and the social construction of deviant identities. Jamison (2006) highlights how stigma insinuates itself into policy decisions resulting in institutional discrimination.

In their study of tertiary students diagnosed with mental illness, McLean and Andrews (1999) found 65% (n = 256) of students surveyed indicated that they would not advise others to disclose and many students indicated their regret in having done so. Concealment of a mental health condition, however, can also limit opportunities as a person tries to avoid possible discrimination. Burris (2006) suggests that those who develop strategies to resist and challenge discrimination, ‘may actually face less stigma, experience less social harm, and be better able to cope with discrimination. At the same time they avoid the life-long hidden distress and unhappiness experienced by people who conceal’ (p. 529).

Figure 1 illustrates mental health pathways that can result in ‘disempowerment’ as a result of stigma from mental illness or ‘empowerment’ when support is provided and stigma is externalised with strategies developed to combat it.

Often, people tend to stereotype a person who is diagnosed with a severe mental illness as someone who is unpredictable and possibly dangerous (Martin, 2006). This results in stigma leading to discrimination, which, in turn, causes disadvantage and restricts opportunities. Frequent setbacks and resultant stress can trigger an episode of mental illness or impede recovery. For some people the stigma of mental illness can cause even more negative impacts than the mental illness itself, with disempowerment occurring on social, cultural, economic and political levels (Corrigan et al., 2000; Link & Phelan, 2006).

As shown in the disempowerment pathway in Figure 1, a person may internalise these negative responses and experiences, either consciously or subconsciously, resulting in loss of confidence and poor self-esteem. Few demands are placed on services with extremely low expectations and grave consequences (Jamison, 2006). Pilgrim (2009) sums up the negative impacts of stigma from mental illness: ‘The stigmatised person is set apart and they suffer the consequences of the social distance created. The person feels depersonalised, rejected and disempowered’ (p. 158). However, as indicated in the ‘empowerment’ pathway of Figure 1, there are those who are able to maintain, or regain, their confidence and self-esteem and achieve personal goals. In this pathway the stigma of mental illness is externalised and viewed as a
means of oppression. Self-expectations are maintained and strategies developed to deal with possible discrimination, resulting in empowerment.

**Service context**

The dominant model of mental health service delivery is primary care partnerships in the community with services provided primarily by general practitioners with assistance from other health care workers or counsellors. However, only a small minority of people treated for mental health concerns are actually referred on to specialist mental health services, with this often for a short-term intervention only (Pilgrim, 2009). This may occur in the community or a short-term acute hospitalisation, with the person soon returning to the primary carer.

Serious concerns have been raised about access to appropriate mental health services. These are particularly in relation to the legislative context, used to determine a person ineligible for treatment by mental health services, if they do not meet the set psychiatric diagnostic criteria. For those deemed eligible for services these can be difficult to access and of varying quality, with this situation exacerbated for those living in rural and remote locations (Mental Health Council & the Brain and Mind Research Institute, 2005).

Mental health services today are provided within dominant paradigm of ‘wellbeing’ that has seen a shift from a ‘disease model’ in health to a ‘wellness model’. The World Health Organisation (2009) defines mental health as ‘a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community’ (p. 1).

Wellbeing programs are increasingly preferred by policy makers with current health care costs under existing primary care models and projected increases
considered unsustainable in the long term (Hassed, Sierpina, & Kreitzer, 2008; Victorian Department of Human Services, 2009; WHO, 2009). However, this shift in funding and emphasis, from primary care to general population wellness models, can also be viewed as a further means of stigmatisation of those diagnosed with severe mental illnesses with them deemed ‘unworthy of social investment’ (Reidpath et al., 2005, p. 1).

The focus of wellness models is on general population health promotion and prevention activities such as nutrition, exercise, stress reduction and developing strategies to deal with barriers to wellbeing. The integration of student wellbeing programs in academic programs has resulted in marked improvements in overall student mental health (Hassed et al., 2008).

Students are able to access community services or use services provided by the university. Most universities have counselling, disability support, medical, and advocacy services provided by student rights officers in the Student Union. Housing, financial counselling and chaplaincy services are also generally available on campus. All of these services were available on the university campus where the current study took place.

**Methods**

The purpose of this exploratory project was to generate knowledge about a relatively under-researched topic: the mental health of university students. An anonymous online survey was sent to all students enrolled in a school within an Australian university identified by the university’s Disability Liaison Unit as having the highest number of students with mental health difficulties using their services. Students were asked to disclose whether or not they had experienced any mental health difficulties during their studies. Those who had experienced mental health difficulties that had affected their studies were then invited to complete the online survey. Open and closed questions were asked focusing on the three areas of disclosure, impact on studies and support (see Appendix A for survey questions).

The self-selection process was a significant aspect of the research as it allowed for participation of students who may not have previously declared experiencing mental health difficulties, formally sought assistance or been diagnosed as such. It also meant that students defined their mental health condition rather than selecting from predetermined categories of ‘mental illness’. The categories identified by the students were compared with those used by mental health services during the data analysis. Previous studies of this nature have surveyed students who have declared a mental illness and registered for Disability Liaison Unit services. Further broad scale research that provides a brief mental health screening tool to select survey participants would be useful to identify the impacts of different types of mental illness, particularly schizophrenia and personality disorder, on students’ education experience and performance.

The survey was posted online for a six-week period with a request to participate sent to 1517 in the school. This method proved effective as students were able to anonymously share their experiences in their own time. A total of 54 students responded – 3.6% of the student body.

The comments and suggestions from the students surveyed are presented, highlighting both obstacles and opportunities encountered by students during their studies.
Findings
Interestingly the self-selection process and open-ended question asking students to provide details of their mental health condition resulted in the same categories as those used by mental health services in the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association. Some of these, however, would be considered physical or intellectual rather than mental health diagnoses. The main conditions were depression \( (n = 35) \) and anxiety \( (n = 23) \). Anxiety included students with eating disorders.

Two students were recorded for both schizophrenia and bi-polar affective disorder. Individual students reported: post traumatic stress disorder, obsessive compulsive disorder, dissociative identity disorder, head injury, Asperger’s syndrome, autism and epilepsy. It was only these last four responses that would not normally be classified as mental health conditions by today’s standards with it noted, however, that this was not the case in the not too distant past.

Just over half of the students \( (n = 28) \) reported multiple conditions, with just under half recording a dual diagnosis of depression and anxiety \( (n = 25) \). The remaining three students reported dual, triple and quad diagnoses. The dual diagnosis was dissociative identity disorder and anxiety. The triple diagnosis was post-traumatic stress disorder, anxiety and depression. The quad diagnosis recorded was Asperger’s syndrome, autism, anxiety and obsessive compulsive disorder.

Two students reported physical problems triggered by their mental health condition. One of these reported mental health difficulties with anxiety that resulted in physical problems that caused further and more serious mental health problems with depression. One student’s physical condition led to mental health difficulties with anxiety. These student responses illustrated the complex interplay between physical and mental health and the importance of a holistic and collaborative approach to mental health care.

Disclosure of mental health condition to staff
Slightly under two thirds of the students \( (n = 34) \), had not disclosed to staff about their mental health condition or the problems encountered with their studies (see Figure 2), even though many were experiencing considerable difficulties.

Figure 2. Disclosure of mental health condition to staff.
Students were asked reasons for not disclosing their mental health condition to staff. Slightly over one third of students \((n = 12)\) stated there was no need to, even though for all but one student, their mental health condition had impacted negatively on their studies. Just under one third \((n = 10)\) did not confide in staff as they were concerned they would be seen as ‘telling lies’ and/or ‘wanting privileges’:

I feel very uncomfortable telling them because I am worried that they will think I’m lying or that my condition’s not bad enough and I just want privileges. (R3)

I feel that I can’t tell staff or students, that I might be resented for being given special treatment that they won’t understand. Sometimes I wish I could explain why things might be difficult for me, but it seems pointless. When I have really bad days, I worry that I’m falling behind, and it’s not like it can be explained and understood as if you said ‘Sorry but I had the flu’ and then caught up and were forgiven. (R4)

Slightly fewer than this \((n = 9)\) were fearful of being found out, judged, stigmatised and discriminated against by being treated differently to other students; possibly losing their place at university and being discriminated against in the workplace as reflected in the following comments:

I’m stubborn and want to pretend like it doesn’t affect me … I don’t like many people to know about it, I don’t want the staff to treat or view me any differently. (R5)

When experiencing a particularly vulnerable episode, if I experience a lack of understanding of my circumstances or feel that I will be judged or considered an inappropriate candidate for my chosen course/career. This could have a highly detrimental impact. (R24)

I fear being found out and considered somehow less than acceptable. I fear that I won’t have the resilience to pull through an episode and get stuff in on time that I will burn myself out keeping up a façade. (R4)

Some students did not disclose for reasons of privacy and confidentiality \((n = 5)\) as reflected in the following student comments:

It’s nobody’s businesses. (R15)

It’s not their problem. (R12)

I have concerns with confidentiality being breached and this impacting on chances for future employment. (R28)

Others were embarrassed \((n = 3)\) or had past bad experiences \((n = 2)\) disclosing to staff. One student was concerned that staff might not understand and ask difficult and personal questions with another student noting that communicating with anyone was difficult when unwell. A further student had only recently been diagnosed:

I don’t think many staff would understand if I told them I was having anxiety or a depressive episode. For some people the ‘cure’ seems to be a few deep breaths and a good nights sleep. Doesn’t work! (R51)

When things are really bad, I cut myself off from everyone, even family, so communicating with anyone, staff or otherwise is very difficult. (R6)
Of those who did disclose their mental health condition to staff \((n = 24)\), the responses were positive for three quarters of these students \((n = 18)\) as seen in Figure 3.

Some students \((n = 4)\) received no response from staff, with two students reporting a negative experience. The main assistance provided was for gaining extensions and Special Consideration. In some instances where extensions were granted, additional support was also needed. Students wanted staff to understand the reasons why they were not finishing their work on time. While support was provided students found it difficult to ask for help as typified in the following comment:

I spoke to staff in order to receive Special Consideration but it has been very uncomfortable. (R55)

It seemed that some staff tried to be helpful but at times their efforts were misguided, resulting in embarrassment for the student, as reflected in the following comment:

I have disclosed in the past and used the Disability Liaison Service to make contact for me. One staff member, contacted by this service on my behalf, then addressed me about my special needs in front of the whole class, with everyone’s attention, when we had a test saying; ‘If you don’t feel well at any time, you can just leave if you need to’. I never attended that class again, failing it, and have never disclosed to any staff since. (R26)

**Most difficult problems**

All but one student reported that their mental health condition had impacted negatively on their studies. Physical, psychological and social difficulties were experienced in the areas of: concentration \((n = 20)\), completing work on time \((n = 16)\), motivation \((n = 12)\) and attending classes \((n = 12)\). Other areas affected included increased levels of stress \((n = 8)\), failing courses \((n = 6)\), poor physical health \((n = 4)\), fearfulness \((n = 2)\) and problems mixing with other students \((n = 2)\). Students were asked what was ‘most difficult’ for them when experiencing mental health difficulties during their studies. The majority of students \((n = 31)\) referred to personal and social issues with 23 students seeing the university as the main source of their difficulties.
**Physical**

Physical problems included tiredness and exhaustion from not sleeping well, extra time required to complete study requirements as well as overall poor physical health. Inadequate sleep affected mood and coping skills as well as energy levels and academic performance:

- Difficulty sleeping impacts on my energy levels. (R56)
- At times I have been unable to focus or to cope with my stress levels. This has been due to the fact I have difficulty sleeping and often lose a lot of weight. (R55)
- I am often tired, weak and have headaches. (R54)

Students who had a first episode of mental illness or who went undiagnosed experienced considerable difficulties often over extended periods:

- Once medicated it only took me a month or so to get back on my feet however there was three months that I went undiagnosed where my studies really suffered. (R22)

**Psychological**

Main psychological difficulties were in relation to concentration and maintaining motivation and focus, as well as managing the disturbing signs and symptoms of the particular mental health condition. For many students this was lowered mood and feelings of ‘overwhelming sadness’.

- Poor concentration impacted negatively on most areas of study including attendance, participation and assessment. Student’s lost confidence in themselves and their abilities:
  - This experience is just like losing confidence in coping with any kind of work. I feel too depressed to even read one sentence sometimes because I just cannot concentrate on anything at all. (R18)

University studies generated considerable stress but, at the same time, aided with recovery:

- I wonder if university is both straining my overall mental health yet helping with my recovery. I have added anxiety due to work piling up, and at points being unable to do anything about it. I still worry about how much work there is and how behind I am getting! Major assessment tasks are sometimes overwhelming and I feel burnt out at the end of semester. (R1)

It was particularly difficult for students to maintain the focus required if they could not see the relevance of their studies in the future:

- Everything is difficult but most of all, seeing the big picture relating to my topics, subjects, course and life! (R20)

Feelings of guilt and failure were experienced in relation to: studies; not submitting work on time and having to apply for Special Consideration; and life in general.
Social
Socially students experienced main difficulties in coping with everyday life as well as their studies. Attending and participating in class was problematic for many students who feared an exacerbation of their condition and that others might find out and not understand. Efforts to conceal mental health difficulties only exacerbated the situation:

I don’t want to attend class or lectures for fear of an anxiety attack and so my marks have suffered. I worry that people will find out about my condition. (R3)

Group work is horrific. (R33)

Having large panic attacks has me walking out of class early and I couldn’t even do an oral presentation – I just had to pack up and leave. (R13)

The university where this study took place did not have an attendance policy. However, unless a course was delivered by distance mode, it was apparent that it was difficult to meet the course requirements for those who did not attend classes. Motivation and attendance were affected during periods of mental illness and hospitalisation:

Some days I am totally unable to attend lectures or tutorials due to needing total bed rest. Usually by end of semester I am completely worn out and need to take a week or two off before I hand in my final assessments. (R25)

Often there were major difficulties in managing to complete assessment activities in the set timeframe with the work submitted not of a standard that students believed reflected their true abilities:

I am unable (and unwilling) to perform assessment tasks when I am undergoing difficulties; my work is of a High Distinction grade and this is my normal mark. I do not feel as if I should necessarily just ‘get it in’ and receive a lower mark than I am capable of. (R1)

Too much work comes at the same time and this frightens me in every single semester. It really affects me emotionally and makes me cry. I continuously lose confidence of not being able to do it. But in the end I manage to do it without sufficient sleep. (R20)

The failure to attend class was connected with low levels of motivation, difficulties with concentration and high stress levels. Students commented on feeling ‘let down’ by the university:

I had enormous difficulty with attending class mainly due to my anxiety problems. I withdrew and eventually stopped attending classes. Absolutely no-one made an effort to contact me, to give me the opportunity to explain my circumstances and then I received this insensitive letter from the university that was not just hurtful but disappointing. I ended up failing two years worth of subjects before I managed to get my anxiety under control. (R2)

Students feared that they might not have the resilience required to ‘pull through’ and worried about lost time when unwell. Raising the issue and asking staff for help was a main difficulty for students. They were particularly concerned that a lack of understanding from staff and students would result in stigma and negative discrimination leading to restricted opportunities at university and in future employment:
I have to ‘explain up’ or ‘explain around’ to staff I don’t wish to confide in if something is handed in late. It is a big issue and trying to act like it isn’t going on can be difficult under a circumstance where marks depend on it. There is also a fear of people’s perceptions of me and how it may effect my professional reputation in the future. So I don’t say much about it at all. (R12)

Some experiences with academic, administrative and staff from counselling and disability services left students feeling disempowered:

I found the consultation very disappointing … I nearly cried when the lady I saw demanded to know how depression could impact on my studies. The experience was really undermining. (R23)

Some students were not seen as eligible for services:

I went to the service and they basically told me that they couldn’t see me on an ongoing basis because there were too many students who needed the service more than me – it felt really horrible. They told me that they were available if I had a crisis or needed an extension on my essays. So it basically felt like I have to wait for when things get really bad before I am able to use their services. (R2)

Additional time was needed during the recovery period to attend regular treatment. The cost of treatment for some students caused financial hardship. Additional difficulties were experienced when language difficulties were present as well as drug use:

If only I was fluent in English and typing all these sentences without thinking of how to form a sentence word by word, I wouldn’t feel that depressed having so much work ahead of me. Moreover I’ll be so much more confident with the work I do. (R19)

**Most helpful assistance**

Students were asked what had been of most assistance to them when experiencing mental health difficulties during their studies.

Half of the students surveyed sought assistance from services within the university ($n = 27$) and just under half from outside services ($n = 26$). A small number of students did not use any services ($n = 8$), with some using a combination of services within and outside of the university.

Just under two thirds of students ($n = 30$) found the university to be most helpful even though many of these students had not disclosed their mental health condition to staff (see Figure 4). The next main source of support was family and friends ($n = 15$), followed by professionals outside of the university ($n = 10$). A small number of students were best able to help themselves ($n = 5$), with one student gaining most support from a pet. All, with the exception of one student who found that ‘nothing was helpful’, were able to access some kind of support.

**University**

Sources of assistance within the university were of both a practical and supportive nature and were provided by academic, administrative, counselling, Disability, Student Union and housing services staff. Students valued online access to staff, course information, support services and information about their rights and responsibilities, so
that they could continue with their studies when it was difficult to attend the university. Special Consideration with extensions of time for assignments, altered assessments and changed exam venues were helpful. The attitude and approach by staff was critical as this impacted on a student’s ability to disclose about a mental health condition and seek the support required. Students appreciated staff who treated them with respect and dignity, were understanding, supportive and trustworthy and provided reassurance, information and advice without being too intrusive. Some students wanted time off to recover yet others did not want this and appreciated staff who reassured them and supported them while they continued with their studies when unwell. Remaining connected to the university was important, with one main point of contact preferred. Given the effort required at times to attend class it was appreciated if this time was well spent. Structured lectures were preferred by those who found it difficult to interact with others:

It is crucial that when I attend, I get a lot out of classes from lecturers who do not waste time and are productive. I learn heaps and my motivation increases. I prefer structured lectures – lectures without interaction (keep this to tutes), so that way if I’m down I can attend lectures and keep up. Do assignment stuff in lectures so I don’t miss out. I am not good with tutes and lots of people. (R2)

**Family and friends**

Family and friends were a main source of support and encouragement as they listened and provided emotional and practical assistance with organisation and time management. Students appreciated a non-judgemental attitude, understanding, kindness and loyalty – in spite of the mental health condition. However, students were mindful of not being a burden and straining these relationships:

I talk to my parents and share thoughts with them. They are usually a lot of help. Maybe this is because they know me better than anyone and they know how they can direct me to a better way out. Talking to friends might also help but I don’t want to spoil their precious time listening to my ‘You know I have so many things to do and I just cannot catch up with everything at the same time’ story. Crying in front of them can trouble them because they would automatically think of what they can do for someone crying, so it is better to cry alone. (R22)
Services outside the university

Services from outside the university were provided by general practitioners, specialist mental health youth services, mental health crisis services, psychiatrists, psychologists, social workers, nurses, counsellors and therapists. Some students required regular medication, with this increased when the symptoms of their condition were exacerbated. Other interventions included counselling and assistance with coping skills and problem solving. Counselling approaches that addressed issues of stigma and mental illness and used an empowerment approach, combined with practical assistance were particularly helpful. Wellbeing approaches, including massage, for stress management and relaxation were also used.

Students found access to a regular worker important for accessing reports for applications for Special Consideration. Having to explain the situation to a stranger was difficult with this even more challenging when unwell and in some cases not possible due to the mental health condition at the time. The financial costs incurred for some of these services caused hardship.

Self-help

Students had a number of self help strategies that they employed. Maintaining a positive outlook and remaining connected with university, family and friends were generally considered important. Approaching staff required considerable motivation and communication skills, particularly at times when these were impaired. Early intervention from academic staff and counselling services was preferred, with concerns that services could only be accessed if problems were acute. Students found it useful to acknowledge their reduced level of capacity at different times and to make allowances for this. A holistic approach to general health and wellbeing was noted, with students finding physical exercise, eating well and regular sleep vital. Relaxing in a quiet area and meditation assisted with stress reduction and remaining calm and positive. One student found playing computer games relaxing. However, not all of the ‘most helpful’ coping strategies were positive as evident in the following student comment:

Cutting, drugs and social isolation are most helpful. Some may say these things are harmful, but without them I wouldn’t have coped. Journal writing also offers an outlet for catharsis. (R23)

This student comment highlights how coping strategies that are socially unacceptable may be the most helpful coping strategies they have access to at the time.

Conclusion

Addressing the stigma of mental illness is a first and crucial step in getting students to overcome their fears and concerns of disclosing to university staff and gaining access to the support they require to succeed in their studies. The United Convention on the Rights of Persons with Disabilities and the Disability Discrimination Act provide a mandate to universities to adopt anti-discriminatory and anti-oppressive practices so that students with mental health difficulties are afforded equal opportunities through access to higher education. This study highlights stigma as a key issue for student mental health. The majority of the students in the study had not disclosed their mental
health condition to university staff due to fears of discrimination and disadvantage arising from the stigma of mental illness. Many of these students experienced difficulties with their studies as they were not able to meet deadlines, with some incurring penalties of ‘at risk’ and exclusion warning notices. This was a disempowering experience as students felt discriminated against when opportunities were curtailed and penalties applied. Students feared discrimination not only in their studies but in future employment. This raises issues of ‘perceptions of’ and ‘actual’ discrimination by university staff. These fears are particularly understandable if staff responses are variable.

The majority of students who disclosed details of their mental health condition to university staff had improved outcomes, receiving helpful assistance primarily for extensions of time to submit work. Some students who did not disclose were able to manage on their own or with support from outside sources, particularly family and friends. The range of approaches and therapies used reflects the current service context of the bio-psycho-social approach to mental health in primary care in addition to preventative wellbeing approaches. Wellness models of health promotion and prevention can be applied on a university-wide basis as well as being integrated into the curriculum. On an individual level an increased incidence of student disclosure of mental health difficulties will only occur when students are confident that they will be treated fairly with respect and dignity by staff who are non-judgemental, understanding and supportive. All academic and administrative staff should receive training on how to recognise signs and symptoms of mental illness and respond in appropriate ways. This includes educating staff in their legal responsibilities of duty of care and ways to support students achieve their educational goals and reduce the harmful impacts of the stigma of mental illness.

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References


Appendix 1. Survey questions

1. What is/are your mental health condition/s?
2. Has your mental health condition/s affected your studies?
3. Have you told to staff at the university about your mental health condition/s?

*For those who answered YES to question 3:*

4. How have staff responded to you in relation to your mental health condition/s?

*For those who answered NO to question 3:*

5. What are the reason/s for not telling staff about your mental health condition/s?
6. What has been most helpful for you when you have experienced mental health difficulties during your studies?
7. What has been most problematic for you when you have experienced mental health difficulties during your studies?
8. What services have you used when you have experienced mental health difficulties during your studies?
9. What is the best way to support you if you are experiencing mental health difficulties during your studies?
10. General comments and/or advice to staff and/or students.